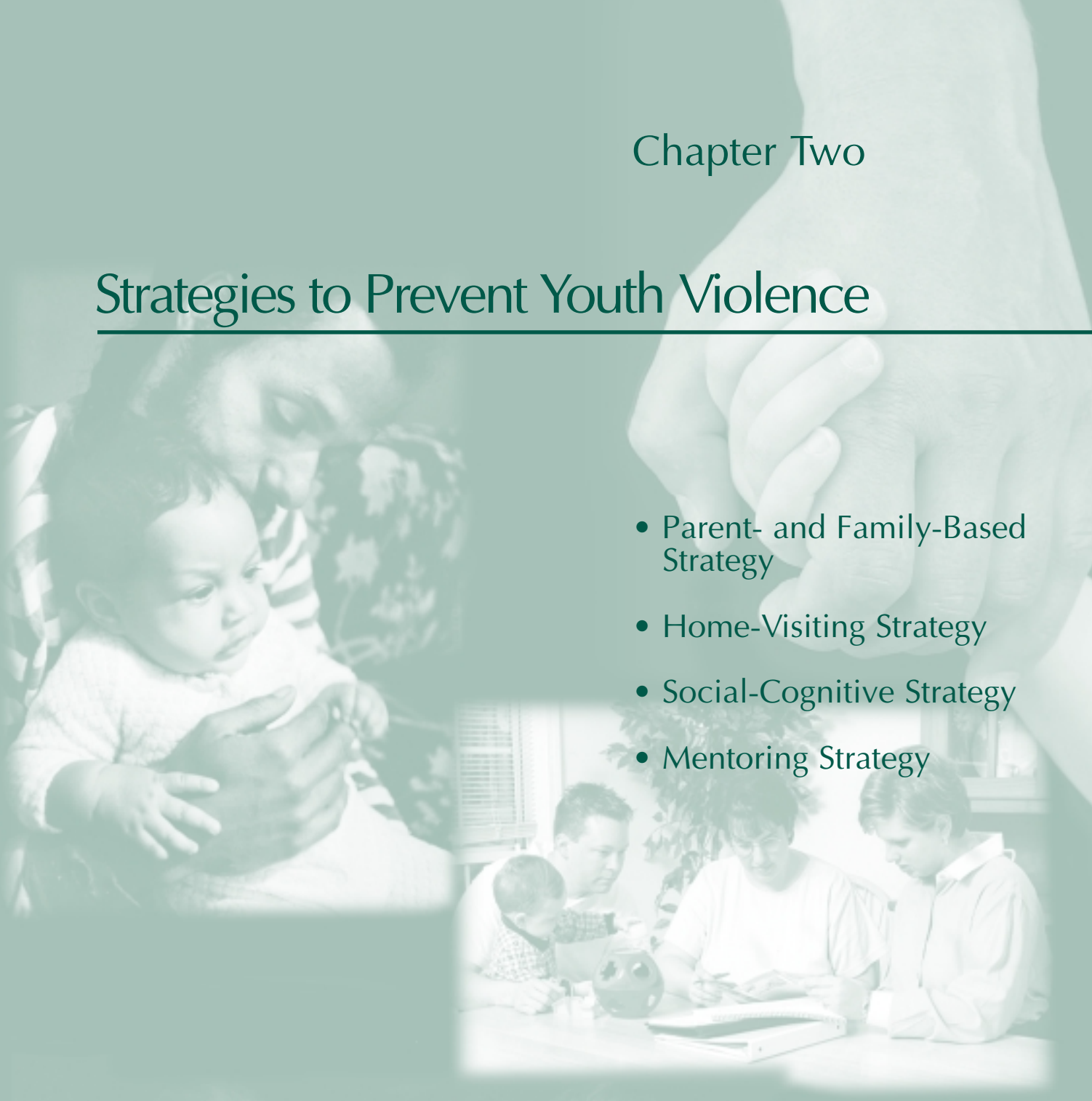
Chapter Two

Strategies to Prevent Youth Violence



- Parent- and Family-Based Strategy
- Home-Visiting Strategy
- Social-Cognitive Strategy
- Mentoring Strategy

Introduction

Best Practices are the elements and activities of intervention design, planning, and implementation that are recommended on the basis of the best knowledge currently available.

Youth violence is a complex public health problem with many risk factors, including individual beliefs and behaviors such as early aggression and use of alcohol or other drugs; family characteristics such as spousal abuse and lack of parental supervision; peer and school influences such as associating with delinquent friends; and environmental factors such as access to firearms. This complexity presents many challenges for those who are working to prevent youth violence (Dahlberg 1998).

This chapter discusses four distinct strategies for combating the problem of youth violence and offers for each strategy best practices—the elements and activities of intervention design, planning, and implementation that are recommended on the basis of the best knowledge currently available. Identified through extensive literature reviews and interviews with experts, these best practices will guide you in developing interventions that meet your community's and participants' needs and fit your goals and objectives. They will help you engage the community in your effort, hire and train intervention staff, and locate resources and partners. They will also help you determine the time frame for your intervention, support and encourage your staff, and keep participants interested and engaged. And they will direct you in monitoring your intervention's progress and evaluating its final outcome.

The goal of this chapter—and of the sourcebook overall—is to share the experiences of others who have implemented interventions to prevent youth violence. In addition to the best practices for each strategy, we have included an *Additional Resources* section. We encourage you to contact the organizations listed and to review the publications described to learn what works particularly well and what barriers and problems may exist for interventions of interest to you. You may also want to review the studies listed in each strategy's reference section (the first strategy includes references for this introduction).

A Note about the Best Practices

Ideally, best practices are based on knowledge derived from rigorous evaluations of interventions reported in peer-reviewed literature. However, a number of factors complicate this approach to identifying best practices for youth violence prevention efforts.

First, because the field of research in youth violence prevention is young, few longitudinal and randomized-control studies have been conducted. Second, while studies have evaluated the outcome of interventions, they have not typically evaluated the effectiveness of individual implementation practices. Therefore, the majority of best practices presented in this sourcebook are based on the hands-on, empirical observations of intervention practitioners and evaluators.

Because youth violence is such a high-priority public health concern, and because it may be years until we can report a significant number of science-based best practices, we felt it was important to include in this sourcebook promising intervention practices as well as scientifically proven ones.

Strategies to Prevent Youth Violence

- Parent- and Family-Based Strategy

Overview of the Parent- and Family-Based Strategy

Parents' interactions with each other, their behavior toward their children, and their emotional state have been shown to be important predictors of children's violent behavior (Webster-Stratton 1997). Hendrix and Molloy (1990), for example, found that poor interactions between a mother and a child at age 1 year predict behavioral problems and aggression at age 6. Having an emotionally distressed parent at age 4 years has been found to contribute to a child's developing conduct disorders and antisocial behaviors (Buka and Earls 1993). Marital conflict and a lack of communication between parents have also been identified as risk factors for youth violence (Biglan and Taylor, in press; Buka and Earls 1993; Tolan and Guerra 1994).

Parent- and family-based interventions are designed to improve family relations.

Parent- and family-based interventions are designed to improve family relations. There is growing evidence that these interventions, especially those that start early and recognize all the factors that influence a family, can have substantial, long-term effects in reducing violent behavior by children. Parent- and family-based interventions combine training in parenting skills, education about child development and the factors that predispose children to violent behavior, and exercises to help parents develop skills for communicating with their children and for resolving conflict in nonviolent ways. This type of intervention is ideal for families with very young children and for at-risk parents with a child on the way.

Best Practices of Parent- and Family-Based Interventions

While the evidence base for parent and family interventions is growing, there is a need for more evaluation research. Those interventions that have been evaluated have typically not set violence reduction as an outcome measure. More commonly, they have measured reductions in delinquent behaviors, conduct disorders, or drug use, all of which are considered precursors to violence.

Despite the need for more evaluation, however, we have learned many lessons about what works using this strategy. This section offers the best practices of parent- and family-based interventions, combining recommendations by experts with general conclusions found in a review of the literature. We have organized the best practices around the steps involved in planning, implementing, and evaluating an intervention (see Chapter 1 for a review of those steps).

Identify the Populations You Want to Reach

Parenting interventions are generally more successful if they are implemented with the unique characteristics and needs of the intended participants clearly in mind. Before you develop your intervention, identify the group you want to reach.

At-risk populations

Substantial research has been devoted to identifying factors within the family unit that put a child at risk for developing violent behaviors. These factors may be related to behaviors and characteristics of either the parents or the child.

Parents' risk factors

Some risk factors that parents possess are dramatic and obvious, such as criminal and violent behavior, alcohol and other drug abuse, child abuse, and child neglect. Other, more subtle predictors include harsh or inconsistent discipline, lack of emotional interaction between the parent and child, and lack of parental supervision (Patterson, Reid, and Dishion 1992; Buka and Earls 1993). Many other behaviors, although not related directly to parenting, are also associated with children's violent behavior. Examples include lack of communication between spouses, marital conflict and divorce, parental social isolation, and parental depression or stress (Buka and Earls 1993; Tolan and Guerra 1994).

One study found that poor, single mothers—faced with many challenges and stressors—are at highest risk for developing parenting patterns that can lead to violent behavior by their children (Patterson, Reid, and Dishion 1992). Parents whose first language is not English often exhibit risk factors resulting from acculturation conflicts. And targeting low-income families has been shown to reduce child abuse and neglect (Campbell and Taylor 1996).

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Avoid identifying socioeconomic status only as the determinant of risk. The perception that an intervention targets individuals simply because they are poor is highly stigmatizing. Find non-pejorative ways to identify people at different levels of risk.

Children's risk factors

Research has found that children at risk for violence can be identified by the time they are 3 years old (Olweus 1978). Factors that put children at risk include living in neighborhoods where violence commonly occurs, witnessing severely violent acts, being a victim of abuse, and associating with "rough" or antisocial peers. Other less obvious factors have also been associated with the development of violent behaviors. These include learning problems, a history of absenteeism from school, and frequent visits to the school counselor. A sudden change in behavior can also signal the beginning of violent tendencies.

High-risk populations

Some children are considered to be at high risk for developing violent behaviors. These children already exhibit clear behavioral markers of violent activity, including the following:

- bullying other children or being the target of bullies
- exhibiting aggressive behavior or being alternately aggressive and withdrawn
- being truant from school
- being arrested before age 14
- belonging to delinquent or violent peer groups
- abusing alcohol or other drugs
- engaging in antisocial behavior, such as setting fires and treating animals cruelly

Young children (10 years and under)

The effectiveness of parenting interventions seems to increase exponentially when children are very young, before antisocial or aggressive behaviors are fully developed (Webster-Stratton and Hancock 1998; Webster-Stratton and Spitzer 1996). By the time

a child reaches adolescence, both the child and the parents are following well-established patterns and are more resistant to long-term change (Patterson, Reid, and Dishion 1992; Taylor and Biglan 1998). And a 14-year-old boy relies much less on his family and is much more susceptible to external influences than a 7-year-old boy (Hendrix and Molloy 1990).

Expectant parents

The earlier in a child's life a parent-based intervention begins, the more effective it is likely to be. With this fact in mind, you may want to consider targeting parents who are expecting a child. Previous research suggests that intervening with a mother during the latter part of pregnancy and continuing with intervention activities during the first few years of her child's life can significantly reduce the risk of conduct disorder and violence (Olds 1997).

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Consider the Cultural and Demographic Context of Intended Participants

When selecting your intended participants, consider their location, age, life circumstances, ethnicity or race, and needs. Try to select a group of people who live near each other and are alike in key characteristics. By targeting a group that is fairly homogeneous, you can better tailor materials and activities so they are more meaningful to participants.

Selecting a homogeneous group increases the likelihood that participants will form support groups and friendships that extend beyond the environment of the intervention. Such an outcome was achieved by the Houston Parent-Child Development Center, which targeted low-income, Mexican American parents (Johnson 1988).

You can also meet the needs of your participants more effectively when participants are alike. Wood and Baker (1999) developed a questionnaire to examine parent preferences, behaviors, and beliefs toward school-based parent-education programs among 395 low-income, culturally diverse parents from two elementary schools. Results indicated that parents of low socioeconomic status wanted to participate in parent-education events, but they were less likely than parents with higher levels of education to attend events at school. The greatest barriers to their participation were difficulty in getting time off from work (27%), cost (27%), lack of transportation (21%), and inability to find or afford babysitting (18%).

Select an Appropriate Setting

Make sure your setting is conducive to interactive exercises and discussions.

The setting for a parenting intervention will likely be a school, community center, church, or other location where a group of people can meet. Make sure your setting is conducive to interactive exercises and discussions.

To reach people who live in remote areas or who have difficulty getting to and from an intervention site, you may need to bring the intervention to them. For example, in remote and rural areas in South East Queensland, Australia, a self-directed intervention delivered by telephone contact and written information was implemented (Connell, Sanders, and Markie-Dadds 1997). Twenty-four preschool children with problem behaviors and their families were recruited for a randomized, controlled study of the parenting intervention. Participants assigned to the intervention read sections of a book on parenting weekly for 10 weeks, completed tasks in the accompanying workbook, and participated in weekly telephone consultations (lasting up to 30 minutes) with a therapist. Parents were prompted to monitor their own and their child's behavior, set goals for behavior change, select strategies, identify strengths and areas for improvement, and select contingent rewards for themselves and their children. Results indicated that this self-directed, minimal intervention increased parents' perception of competency; reduced dysfunctional parenting practices; reduced disruptive behavior by the child; and significantly reduced mothers' feelings of anxiety, depression, and stress. Improvements in child behavior and parenting practices achieved at the end of the intervention were maintained at follow-up four months later.

Another self-directed intervention is Parenting Adolescents Wisely, a CD-ROM-based program. It was successfully implemented in Appalachia, where participants had little or no computer literacy (Olds 1997). Because the skill-building exercises require no orientation or supervision by staff, they can be conducted at any time, in locations most convenient to participants (Kacir and Gordon 1999). This intervention has also been successful with teen mothers and clinic-referred teens and parents (Lagges 1999; Segal 1995). With no other intervention or support, the rate of problem behaviors for children in the intervention dropped by half at one, three, and six months after their mothers participated in the intervention.

Involve the Community and Parents in Planning the Intervention

Organizations sponsoring parent- and family-based interventions should participate in developing the intervention. This involvement will help them feel "ownership" of the intervention so they are more likely to support its objectives, commit to evaluating outcomes, and hold themselves accountable for the impact of the intervention.

Parents also need to participate in the development process. The more active a role parents play in an intervention from its inception, the greater their sense of empowerment and accountability both during and after the intervention. Parents can also provide unique insight to help practitioners more closely tailor the intervention to participants' needs and priorities.

Set Clear Goals and Objectives for Intervention Outcomes and Implementation

Set clear, specific, observable goals and objectives for each intervention. They will help you evaluate an intervention's effectiveness and give parents and staff a sense of day-to-day accomplishment. Make sure goals and objectives are behavior-based and outcome-oriented—for example, reducing school truancy by 50 percent or establishing and keeping a weekly family budget. If you are modeling your intervention after one that has been proven effective, use the original intervention's evaluation framework to shape your goals and objectives.

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Involve parents in setting objectives. Have them outline, with the practitioner's guidance, what they think their family can achieve and in what time period. Starting this kind of new initiative may seem overwhelming to parents: they are being asked to change the way they parent their child, even the way they conduct their daily affairs. Setting clear, definable goals enhances parents' sense of control and accountability (McMahon et al. 1996).

Select the Best Intervention for Your Participants and Develop Appropriate Materials

The intervention you select must be appropriate for the ages of the participants' children, the degree of violent behavior or level of risk for such behavior, and participants' cultural characteristics. It must also take into account family dynamics (how members interact with one another), the external environment (e.g., schools, housing), and the family's financial situation.

Consider the children's ages

A child's age influences many factors of parenting, from nurturing to discipline. For example, parents of a young child should set limits for their child's behavior, but with an older child, parents may want to negotiate those limits. Therefore, the contents of your intervention will be driven, in part, by the age of the children.

Young children (ages 10 and under)

Interventions for parents of young children often have the best chance of effecting long-term, positive change because the behavior patterns of both parents and children have not been firmly established; they are still fairly malleable (Taylor and Biglan 1998). When developing an intervention for parents of preschool- and elementary school-age children, include an overview of child development so participants can set realistic, age-appropriate expectations about their children's behavior.

The following are other principles to include in an intervention for parents of young children:

- Playing with the child versus directing the child
- Praise and rewards for positive behavior and correction of undesired behavior
  - In order to change a child's behavior, positive reinforcement must be accompanied by appropriate, consistent, measured discipline of undesired behavior (Taylor and Biglan 1998).
- Decisions appropriate for children to make and those which should be made by the parents
- Supervision and discipline
  - Children need a consistent set of rules to follow, and parents need to discipline children in nonviolent ways when they break those rules.
- Influence of caregivers on children's beliefs, attitudes, and behaviors
- Impact of seeing violence, both in person and on television and film

One intervention that has worked well in families with young children is Parent-Child Interaction Training. In this intervention, low-income African American parents of preschool children with behavior problems attended five two-hour small-group sessions composed of instruction, role-playing, and supervised play sessions. After one year, children in the

experimental group showed less aggression, hostility, anxiety, and hyperactivity than children in the control group (Strayhorn and Weidman 1991).

Adolescents and teens

For parents of adolescents and teens, an intervention should explain appropriate developmental issues, including sexuality, growing independence, and the likelihood of rebellious behavior. Curricula for parents with older children should also discuss the following:

- Reframing the underlying motives for a child's behavior in non-pejorative terms (e.g., belonging, competence, reducing fear)
- Increasing positive and decreasing negative communication patterns among immediate family members, extended family, and peers
- Improving parents' ability to identify positive role models among extended family and the community and to minimize negative influences

The Adolescent Transition Program is one intervention that has been proven effective for families with older children. Designed for parents of middle-school students at risk for substance use, academic failure, and antisocial behavior, this intervention seeks to improve seven classic parenting skills: making neutral requests, using rewards, monitoring, making rules, providing reasonable consequences for rule violations, problem-solving, and active listening. Classes are conducted weekly for 12 weeks in groups of eight to 16 parents and follow a skill-based curriculum. In a randomized control trial of the program, which involved 303 families over a four-year period, participants were compared with parents on a three-month waiting list. Parents in the program reported a lower tendency to overreact to their child's behavior, greater diligence in dealing with problem behavior, and less depression. There was also some indication of lower levels of daily antisocial behavior from the child. The more sessions a parent attended (many did not complete the 12-week program), the greater the reported improvements in behavior. We should note, however, that this evaluation is limited because it was based on the parents' assessment and interpretation of behavior rather than on objective measures (Irvine, Biglan, Smolkowski, Metzler, et al. 1999; Irvine, Biglan, Smolkowski, and Ary 1999).

Don't be afraid to target high-risk families

Many parents whose children have already displayed antisocial behaviors or have committed delinquent acts live in a stressful and isolating environment. Such parents may be economically distressed and socially cut off, with little access to financial or psychological support. The common belief is that it's extremely difficult to implement effective parent-training programs for disadvantaged parents, particularly low-income single mothers. However, this perception is misleading. Interventions that involve parents in planning, recruitment, group leadership, and priority-setting have successfully enlisted and retained low-income participants, have positively influenced parenting behaviors, and have enhanced family and community support networks (Webster-Stratton 1998).

Research has demonstrated the effectiveness of working with parents who are at increased risk for raising antisocial children.

Violence prevention research on high-risk populations has demonstrated the effectiveness of working with parents who, because of socioeconomic and psychological factors—such as low income, single motherhood, or a history of abuse—are at increased risk for raising antisocial children. Several interventions have investigated the effectiveness of providing high-risk parents with parent training before or immediately after the birth of a child. These initiatives were designed to help parents manage their children and their lives more effectively and reduce the stress typically experienced by parents in the first few years of a child's life. The interventions offered a range of services: parent counseling, strategies for problem-solving, training in parenting techniques, and help in developing social support systems. Some even covered the children's childcare and healthcare expenses. One example of such an intervention has been offered by the Houston Parent-Child Development Center, which serves as a "parent college" for Mexican American families. Up to eight years after the intervention, children of participating parents had a lower incidence of reported problem behaviors in school than did control children (Johnson 1988).

Interventions for parents of delinquent children

Many parents of children with serious behavior problems use ineffective disciplinary techniques. For example, parents of delinquent children tend to be inadequately involved in monitoring their child's day-to-day activities, to be inconsistent in applying punishments, and to display marginal levels of involvement in such areas as the child's academic progress (Dishion, Patterson, and Kavanagh 1992; Buka and Earls 1993; Bank et al. 1991). Often, a destructive pattern of "coercive interaction" exists between the child and the parents, characterized by a cycle of the child misbehaving and the

parents threatening the child (Patterson, Reid, and Dishion 1992). While this reaction by the parents may be effective in the short-term, it promotes further aggression by the child in the long run. The first step in breaking this cycle is to change the parents' tactics and teach them alternative responses to their child's negative actions.

The coercion model is one intervention that can break this cycle. It involves eight family groups who participate in 12 weekly sessions, each lasting 90 minutes. The group sessions are supplemented with four individual family sessions. This model teaches parenting-behavior skills such as monitoring children's actions, fostering prosocial behavior, disciplining without aggression, and problem-solving through exercises, role-play, and group discussion. Various evaluation procedures over time have shown this model to be effective in reducing problem behaviors and increasing family unity (Patterson, Reid, and Dishion 1992).

Another effective intervention for families with chronically delinquent children was developed by the Oregon Social Learning Center (OSLC). In this study, 55 families of boys who had multiple arrest histories and had committed at least one offense deemed "serious" by the court were assigned to either the OSLC parenting-training intervention or to a community treatment group involving 90-minute family-therapy sessions for approximately five months. Parents in the OSLC group were taught to monitor, record, and react to the daily behavior of their boys. Parents and children developed behavior contracts that specified prosocial and antisocial behavior and the positive and negative consequences that would result. Each family received an average of 21.5 hours of therapy and 23.3 hours of phone contact. Families were free to contact intervention staff for "booster shots" of support after the treatment year.

A significant reduction in arrests was achieved for both the intervention and the control group. However, the OSLC treatment produced results more quickly and with one-third less reliance on incarceration. The researchers state that the main outcome of the treatment may have been to help the parents remain actively involved and responsible for the conduct of their boys. We should note that researchers found the clinical work with these families to be extraordinarily difficult, and it took tremendous effort to prevent staff burnout (Bank et al. 1991).

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Interventions for abusive parents

Parents who abuse their children need to build nurturing skills as alternatives to their abusive parenting behaviors and attitudes. The Nurturing Parenting Programs, family-centered interventions based on a re-parenting philosophy, teach those skills. Parents and children attend separate groups that meet concurrently. Cognitive and affective activities are designed to build self-awareness, positive self-concept/self-esteem, and empathy; teach alternatives to yelling and hitting; enhance family communication and awareness of needs; replace abusive behavior with nurturing; promote healthy physical and emotional development; and teach appropriate role and developmental expectations. Thirteen different interventions address specific age groups (infants, elementary school-age children, and teens), cultures (Hispanic, Southeast Asian, African American), and needs (special learning needs, families in alcohol recovery).

The initial Nurturing Program for Parents and Children 4 to 12 Years was extensively field-tested with 121 abusive adults and 150 abused children. Significant improvements were found in the attitudes of both parents and children, in personality characteristics of both parents and children, and in patterns of family interaction. Evaluations of subsequent nurturing programs have shown similar results (Bavolek 1996).

Empower parents

A fundamental principle of effective parenting interventions is empowering parents to deal with their children. Parents—especially those of delinquent children—tend to feel out of control in many aspects of their lives. They may feel demoralized, frustrated, or depressed by their inability to parent effectively (Dishion, Patterson, and Kavanagh 1992). Interventions should increase parents' sense of self-control and self-efficacy, giving them confidence in their interactions with their children and making them feel accountable in a positive way for improvements in their children's behavior (Prinz and Miller 1996).

One way to empower parents is to give them information that will help them understand and react appropriately to their children's behavior. Interventions should provide training on how to nurture and communicate effectively with children, negotiate family rules and consequences, praise and reward children for prosocial behavior, and discipline without violence. They should teach parents effective means of punishment, such as "time outs" and loss of privileges, that do not promote aggressive interactions between parent and child.

Another empowering technique is to encourage parents to participate in the problem-solving process (Cunningham 1996). For example, in a collaborative group-therapy model used at the University of Washington Parenting Clinic, the therapist solicits parents' ideas, feelings, and information about their cultural background. In this model, therapists and parents feel joint ownership of solutions and outcomes (Webster-Stratton and Herbert 1994). In Los Niños Bien Educados, a program targeting Latino American families, participants were asked to define important cultural concepts about parenting. Participants defined what "bien educados" meant to them and recalled the cultural proverbs that were used in their own and their grandparents' homes (Alvy and Rubin 1981).

You can also build in activities to involve and empower parents, to make them feel that they are vital contributors to the intervention. For example, have parents bring refreshments to meetings, have them monitor their family's progress, or enlist participants to lead pep rallies.

Consider cultural and demographic issues

Some participant groups have cultural beliefs or behaviors that present unique challenges for practitioners. Identify cultural issues up front and design intervention materials to address them. Culturally relevant content promotes a strong sense of group ownership, ethnic identity, community-building, and advancing one's group as a whole (Alvy 1994).

The Effective Black Parenting Program is a cultural adaptation of a generic parenting skill-building intervention called Confident Parenting (Alvy and Rubin 1981). This program reduced parental rejection, improved the quality of family relations, and reduced child behavior problems among African American families living in South Central Los Angeles. Key intervention components, in addition to skill building, included discussions contrasting "traditional" discipline (e.g., punishment, spanking) with "modern" self-discipline (internalized standards of effective behavior); discussion and reinforcement of issues related to "pride in blackness"; and the use of a black achievement perspective to link the life goals the parents had for their children with the abilities and characteristics the children need to achieve them (Myers et al. 1992).

Among some families of low socioeconomic status, parents' low level of education can make traditional communication channels ineffective. To address this challenge, program planners have developed interventions that de-emphasize written materials and verbal teaching methods, opting instead for role-playing and modeling techniques (Knapp and Deluty 1989).

For many groups, interactive teaching techniques are most effective. These techniques incorporate not only didactic teaching but methods such as role-playing and problem-solving exercises. However, some parents prefer didactic authority figures and mistrust overly friendly strangers. With these groups, a practitioner would want to begin with a more formal style and ease into interactive teaching methods to avoid being viewed as disrespectful.

To achieve long-term effects, interventions must also address the context in which parenting takes place.

Address environmental and financial concerns

Interventions that focus solely on parents' behavior may not result in changes that parents can sustain in the environment outside the intervention. To achieve long-term effects, interventions must also address the context in which parenting takes place. Today, the most successful interventions have been expanded to help parents improve their "life skills" and help them deal with issues such as social isolation, stress, depression, marital conflict, housing, and money matters. The general principle behind these broad interventions is that parents who are better able to manage everyday life issues will have the physical, psychological, and social resources to parent more effectively.

A variety of interventions integrate parenting life skills. One of the most researched, Henggeler's Multisystemic Therapy Program operates on the premise that a family is an interconnected unit in which a series of individuals (parent, child, siblings, extended family members) and external factors (work, school, housing situation) interact with one another to create an ongoing family dynamic (Borduin et al. 1990). Intervention activities are designed for each family on the basis of the family's risk and protective factors.

In a series of randomized control trials, in a variety of settings, the multisystemic approach has been successful. A study in Simpsonville, North Carolina, involved adjudicated youths who had at least one violent offense. After 59 weeks, the youths who received the multisystemic therapy (MST) had significantly fewer arrests (.87 versus 1.52) and fewer weeks incarcerated (5.8 versus 16.2) than youths receiving the usual services. The MST-intervention families also reported improved family cohesion. A study in Columbia, Missouri, compared MST with individual therapy (IT) among 17-year-old multiple offenders and their families. At 5-year follow-up, MST youths were less likely to be arrested again, the families receiving MST reported and showed more positive changes in their overall family environment, and the MST parents showed greater reductions in

psychiatric symptoms (Henggeler et al. 1996). MST was also found to be effective in the treatment of adolescent sexual offenders. Youths in the MST group had significantly fewer subsequent arrests for sexual crimes than did youths in the IT group (Borduin et al. 1990).

Select Staff Appropriate For Your Intervention

With the parent- and family-based strategy, the quality of the relationship between the practitioner and the parent can profoundly affect the outcome of your intervention. Therefore, staff must be selected with great care, keeping in mind both the needs and desires of participants and the requirements of your intervention.

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The persons best suited for parent-training intervention have the following characteristics:

- Commitment to the intervention's objectives
- Experience with family interventions
- First-hand knowledge about the community (they either live or work there)
- Good interpersonal communication skills
- Knowledge of group dynamics
- Ability to manage resistance from participants

In addition, staff should live near enough to participants to allow for frequent contact. They must also be available to work during the times that are most convenient to participants, usually during evenings and weekends.

It may be helpful to select staff members who have characteristics like those of participants. For example, you could pair single mothers with staff who are also single mothers or African American participants with staff of the same race. The Strengthening Families Program finds it effective to match therapists with parents as similar as possible in age, social standing, and cultural background (Kumpfer, Molgaard, and Spoth 1996).

Consider involving alumni of previous interventions to help bridge the gap between the practitioners and parents and to provide parents with support from someone who's "been there." Patterson's Coercion Model, for example, involves parent alumni as mentors to participating parents; the Strengthening Families Program hires parent alumni to support and reassure participants in an attempt to reduce drop-outs (Dishion, Patterson, and Kavanagh 1992; Kumpfer, Molgaard, and Spoth 1996).

Train Staff Members

In successful parenting interventions, the practitioner must form a bond of trust, respect, and collaboration with parents (Taylor and Biglan 1998; Johnson 1988; Webster-Stratton and Spitzer 1996; Prinz and Miller 1996). Training for your intervention should prepare staff to play the role of teacher, supporter, and facilitator.

In addition to teaching staff how to carry out the activities of your intervention, training should include information about child-rearing principles, participants' values, and other cultural and religious beliefs that may impact how parents interact with their children or with intervention staff. It should also show staff how to employ an interactive teaching method, engaging participants in group discussions and role-playing exercises; this technique is more effective than a formal, didactic style. Provide staff with a training manual they can refer to throughout the intervention.

Recruit Families

To recruit participants for your parenting intervention, work with community groups, churches, mental health facilities, law enforcement agencies, and schools in your area. Get involved personally in the recruitment process. Phone or visit parents at home or speak with them in public places, communicating to them that you understand and respect the challenges they face. Consider hiring or assigning administrative or public-relations staff to assist with recruitment. When targeting high-risk families, you may need to enlist the help of a community gatekeeper—for example, a trusted school official, community elder, or minister—to facilitate referrals.

You may need to offer parents incentives to encourage participation, especially if you are targeting at-risk parents. You are, after all, asking them to commit to making profound changes, something parents may not enter into lightly. Think about what would entice parents, such as money, transportation fare (subway, bus, taxi), food, or free childcare. Ask local businesses to contribute products and services that would interest intended participants.

Implement Your Intervention

How you implement your intervention will depend on many factors, including the activities planned and the participants involved. However, the following principles apply to any parenting intervention:

- Schedule activities at times and locations that are convenient to parents.
- Give staff appropriate titles—that is, if your intervention is not therapy, per se, refer to staff as session leaders, practitioners, facilitators, or instructors rather than therapists.
- Build on the knowledge parents already have.
- Minimize lectures; maximize interactive teaching opportunities.
- Make sure staff model the behaviors being taught (e.g., effective listening skills, non-aggressive reactions to conflict).
- Offer opportunities for parents to ask questions, offer feedback, and practice the skills taught.
- Implement all components of an intervention that has been proven effective. Using only selected components may not produce the results of the original intervention.

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It may help to explain the behavioral theories that underlie the parenting techniques being taught. For example, parents are much more likely to persevere in using recommended disciplinary tactics, particularly when they do not result in immediate improvements in their child's behavior, if they have a good overall understanding of the behavioral principles on which the tactics are based.

Intervention delivery may vary depending on children's ages and families' risk factors

The age of the children in participating families will affect delivery techniques. What works for parents with very young children may not be as effective for parents with older children.

Young children

For interventions designed to influence families with young children, group-based parenting interventions (ideally, with seven to nine families) have been shown to be as effective as one-on-one training, and they are more cost-effective (Webster-Stratton 1984). Another method that has worked with families of preschoolers and elementary school-age children is the Parent-Child Interaction Training Program, which teaches parents

productive behaviors and strategies for interacting with their children. It includes supervised individual play sessions between parent and child that give parents an opportunity to test their new skills.

The following techniques have also been effective among this age group:

- Home visits that supplement group sessions
- Self-administered video training combined with a brief, two-session consultation
- Videotapes that present models of effective parenting techniques (provided participants are able to identify with the characters portrayed) and vignettes of ineffective techniques

At-risk and high-risk older children
For interventions reaching parents of at-risk older children, the following formats—used individually or in combination—are most effective:

- Group sessions with parents only
- Individual family therapy
- Group sessions with multiple families

Helping parents contact one another and engage in activities outside of regularly scheduled training sessions can help maximize your intervention's results.

For families with high-risk older children—especially children with multiple risk factors—individualized and home-based family interventions are most effective. Interventions for these families should:

- Address logistical challenges;
- Adhere to a clearly-defined format;
- Enlist the support of groups that can help reinforce desired behaviors.

When working with high-risk families, it is essential to link parenting interventions to child-based interventions that actively involve the child at risk. The Multisystemic Therapy Program, for instance, develops ongoing strategies and goals for every relevant member of the family. It requires the child to perform certain tasks and follow certain behaviors, and it requires the parent to monitor and reward or discipline the child's actions (Henggeler et al. 1996).

Use the full range of parent-training activities

The most effective parent- and family-based interventions include a variety of activities, including multi-session classes for small groups, one-day seminars for large groups, video and audiotape training materials, self-instruction activities, and home projects to implement skills.

A number of studies have demonstrated the success of videotape modeling as a mechanism for educating parents and stimulating discussion. While video-based interventions can be effectively self-administered, the best results are obtained when the video is combined with group interactions (Webster-Stratton, Kolpacoff, and Hollinsworth 1988). In five randomized studies with more than 500 families, an intervention incorporating the videotape modeling and parent-group discussions resulted in greater reductions in child conduct problems and more significant improvements in parents' disciplinary approaches and parent-child interactions than did one-on-one parent training, discussion groups without videotape modeling, or videotape modeling without discussion (Webster-Stratton 1996).

Additional research has been conducted on early interventions with videotape modeling using the BASIC and ADVANCE Parent Training Videotape Modeling interventions, the PARTNERS 1 Academic Skills Training intervention for parents, the PARTNERS 2 intervention for teachers, and the KIDVID Child Social Skills and Problem-Solving Training intervention for children ages 3 to 8. Although interventions with self-administered activities alone did reduce conduct difficulties, better results were achieved when interventions also included parent training in interpersonal and coping skills (Webster-Stratton 1996).

The Functional Family Therapy (FFT) model combines assessment, therapy, and education to address dysfunctional communication styles in families with delinquent children (Alexander and Parsons 1982). In the assessment phase, therapists evaluate family behavior patterns and gather information on problem behaviors. The therapy phase is designed to change attitudes, expectations, emotional reactions, and perceptions to reduce blame among family members. The education phase teaches skills in family communication, relationship-building, and problem-solving; reinforces positive interactions and manages conflict; and teaches parents how to reward and reinforce prosocial behavior.

In a number of controlled studies, FFT has been shown to modify dysfunctional communication and reduce rates of delinquency among treated youths and their siblings (Barton et al. 1985). Gordon and colleagues (1988) replicated the FFT model in a group of 54 rural, economically disadvantaged juvenile offenders in southeastern Ohio. Half of the group was non-randomly assigned to receive in-home FFT from psychology graduate students. Most of this group had committed multiple serious offenses and had been assigned to family therapy by the court. A control group of 27 lower-risk delinquent youths received only probation services. After 2 1/2 years, recidivism rates were 11 percent in the treatment group and 67 percent in the comparison group. A later study that measured changes in the group at the end of an additional 32-month period (after the subjects had become adults) found recidivism rates of 9 percent for misdemeanor and felony offenses in the treatment group and 41 percent in the comparison group (Gordon, Graves, and Arbuthnot 1995).

Parenting patterns are hard to change—there are no "quick fixes."

Set a realistic time frame for your intervention

Parenting patterns are hard to change—there are no "quick fixes." Expect your intervention to take at least several months. A desirable duration for interventions targeting at-risk families is approximately 22 sessions; 12 sessions is typically appropriate for families not considered at risk.

In most cases, sessions should occur at regular intervals (e.g., weekly or biweekly) and last for no more than two hours. Longer sessions have been successful in some programs, as long as frequent breaks were provided. Formats involving out-of-home group sessions should be convenient in terms of childcare, transportation, and the availability of food.

Support intervention staff to prevent burnout

Parent- and family-based interventions can be challenging and emotionally taxing for intervention staff. It is critical that you provide them with support and encouragement. Staff need coaching and consultation regularly and should be given plenty of opportunities to talk with a supervisor about how well they are meeting the intervention objectives as well as about personal, job-related objectives. Consider hiring staff on a part-time basis or making intervention implementation a component of a full-time position. This may help prevent staff burnout. It is also beneficial to provide staff members with flexible schedules.

Encourage participants to stay involved

Parent- and family-based interventions can last for many months with results that are subtle and gradual. You will need to

maintain participants' interest in your intervention and keep them focused on the long-term goal. In addition to offering incentives like free food, transportation, and childcare, plan events that will entice parents to complete the intervention. For example, hold graduation ceremonies or provide gift certificates as a reward for completion.

Monitor Progress and the Quality of the Implementation

As your intervention moves along, monitor activities to be sure they are being carried out as planned. This is especially important if you are implementing an evaluated intervention—you need to follow all steps to make sure you achieve the same results.

The following steps will help you determine if your intervention is on track:

- Base staff supervision on outcomes.
- Record accomplishments as they occur.
- Track attendance to sessions.
- Have someone who is not involved in delivery of the intervention perform spot-checks of activities.
- Have parents keep a log of what kind of activities and information were delivered.
- Gather additional feedback from parents and staff that can help you fine-tune the intervention.

Evaluate Outcomes

From the beginning, consider how to evaluate the outcome of your intervention.

From the beginning, consider how to evaluate the outcome of your intervention. Have participants assess changes in their own behavior and that of their children. Intervention staff should also evaluate those changes. You can use a third party to identify changes, as well. For example, review school records of children whose families participated in the intervention to see if rates of delinquent behavior or absenteeism have dropped.

Expect setbacks

Behavior change does not happen overnight. Long-standing family issues, crises, and disciplinary problems cannot be cured with a single treatment. Set realistic expectations for your intervention and let parents know that obstacles and setbacks will occur along the way (Taylor and Biglan 1998). Informing parents that they will probably face resistance and recurring behavior problems from their children will better prepare them for these difficulties so they can remain committed to the intervention (Prinz and Miller 1996).

Maintain Results After Implementation

Without the guidance and support of intervention staff, participants may find it difficult to keep momentum going after the intervention ends. You can take some steps to maintain the positive results of your intervention after it has been completed. For example:

- Provide a follow-up source for parents to call with questions and concerns.
- Offer "booster" sessions.
- Help parents form support groups.
- Refer parents to resources for marital and financial help.
- Link parents with organizations that can reinforce the values and behaviors taught by your intervention.
- Tie your intervention with the activities of other relevant community groups (such as civic and religious groups), parks and recreation activities, and school programs.

Follow-up activities, conducted several months or more after the original intervention has ended, can also increase the long-term benefits of your effort. These activities can be especially effective when targeting families with young children. Buka and Earls (1993) likened violence prevention strategies to immunization: a "vaccination" at an early age followed by periodic "booster sessions" throughout childhood and adolescence. Scheduling follow-up activities to coincide with difficult developmental periods, such as a child's initial entry into school or transition to a new school (for example, moving from elementary to middle school), can be particularly helpful in addressing behavioral problems. And involving practitioners and staff from the original intervention can lend continuity to activities.

Link Parent- and Family-Based Interventions with Other Strategies

While parent-based interventions are among the most effective strategies known thus far for preventing violence by children and adolescents, once children reach school age it is essential to complement this strategy with one that addresses the influence of factors outside the home (Taylor and Biglan 1998; Brestan and Eyberg 1998).

Negative academic and social experiences in school can result in a child's developing violent behavior or associated risk factors.

Evidence has shown that a partnership between parents and the school is more effective than parent-based strategies alone (McMahon et al. 1996; Webster-Stratton 1993; Coleman 1997). A coordinated effort among parents, teachers, school psychologists, and school nurses can identify problems early so practitioners can intervene with programs to teach problem-solving, develop conflict-resolution skills, and enhance academic skills (Honig 1999; Schweinhart 1999).

Summary

The relationship between parent and child can play a profound role in the child's development of violent behavior or behaviors shown to be precursors of violence. Parent- and family-based interventions have proven highly effective in preventing such behaviors, especially when they address families' environmental, cultural, and financial needs and are paired with other interventions based in the school or community.

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Additional Resources on Parent- and Family-Based Interventions to Prevent Youth Violence

The following intervention summaries have been adapted from information listed on the Strengthening America's Families web site, a project funded by the Office of Juvenile Justice and Delinquency Prevention. Further details about the interventions are available at www.strengtheningfamilies.org and from the contact person provided with each description. This listing is provided as a service to readers, but the presence of an intervention on this listing does not imply endorsement by CDC or the Department of Health and Human Services.

Bethesda Family Services Foundation

This foundation provides comprehensive individual and family-centered treatment to children ages 10 to 18 who were referred by the court as a result of delinquent offenses (referral to the program is in lieu of jail time). The intervention provides treatment for the entire family during nontraditional hours. Youths receive at least six months of treatment, and parents attend meetings and training sessions.

Dominic Herbst, President
P.O. Box 210
West Milton, PA 17886
Phone: 570-568-2373
E-mail: staff@bfsf.org

Birth to Three

This education intervention for parents with infants and young children strives to strengthen families and prevent child abuse. A variety of interventions is offered, including the Infant Program (a five-month parenting-confidence curriculum), Making Parenting a Pleasure, and Teen Parents.

Minalee Saks, Executive Director
86 Centennial Loop
Eugene, OR 97401
Phone: 541-484-5316
E-mail: birthto3@efn.org
Web site: www.efn.org/~birthto3

CEDEN Health and Fair Start Program

The Center for Development, Education, and Nutrition provides comprehensive services to strengthen families in need of prenatal, early childhood, and parenting education. The Health and Fair Start Program serves primarily low socioeconomic status families and children younger than five years who have developmental delays.

Terry Aruguello, Program Coordinator
1208 East 7th St.
Austin, TX 78702
Phone: 512-477-1130
E-mail: CEDEN@bga.com

CICC's Effective Black Parenting

Created to meet the needs of African American parents, the Center for the Improvement of Child Caring fosters effective family communication, family values and identity, and healthy self-esteem. It provides basic parenting strategies taught by black educators and mental health professionals using a culturally appropriate curriculum.

Kerby T. Alvy, Ph.D., Director
Center for the Improvement of Child Caring
11331 Ventura Blvd., Suite 103
Studio City, CA 91604-3147
Phone: 818-980-0903
E-mail: cicc@flash.net
Web site: www.ciccparenting.org

Families and Schools Together Program

FAST is an intervention for at-risk children and adolescents ages 3 to 14. Its structure gives young people and their parents both a voice and a role in the prevention process. The intervention develops separate support networks for youths and parents, using a multi-family format, and brings them together for family activities.

Lynn McDonald, Ph.D.
11770 West Lake Park Dr.
Milwaukee, WI 53224
Phone: 800-221-3726
E-mail: mrmcdona@facstaff.wise.edu

Families in Focus

This family skills training intervention is designed to strengthen the family and prevent social and behavioral problems. The intervention was originally designed for high-risk youths ages 8 to 14 but has also been delivered to children of all ages. A Home Learning Guide and Family Profile Questionnaire help direct families to specific activities.

Mary Altizer, Administrative Assistant
Families Worldwide
75 East Fort Union Blvd.
Midvale, UT 84047
Phone: 801-562-6178
E-mail: maltize@homeplus.com

Family Support Program

This intervention uses case-management services to reduce juvenile delinquency among at-risk middle-school children and their families. Case-management services identify family needs and develop an individual plan for the family. Youths attend after-school groups and meet with coordinators individually. Family members attend workshops.

Chris Corallo, School Administrator
Middle School Rd.
Rocky Mount, VA 24151
Phone: 540-483-7209
E-mail: ccarallo@frco.k12.va.us

First Steps/Fremont County Family Center

First Steps offers comprehensive child development and parenting services for families with children from birth to 5 years. The intervention, which operates as part of the Fremont County Family Center, incorporates monthly home visits and play groups that are held four times a week for children, siblings, and parents.

Katherine Bair, Homevisiting Coordinator
1401 Oak Creek Grade Rd.
Canon City, CO 81212
Phone: 719-269-1523
E-mail: fcfc@ris.net

Focus on Families

This intervention focuses on families with parents who are addicted to drugs, enrolled in methadone treatment, and have children ages 3 to 14. Families participate in an orientation and then attend curriculum sessions for 16 weeks. Parent sessions are held in the mornings, and parents and children attend practice sessions in the evenings.

Kevin Haggerty, M.S.W.
Social Development Group
9725 3rd Ave., NW, Suite 401
Seattle, WA 98115
Phone: 206-685-1997
E-mail: haggerty@u.washington.edu

Functional Family Therapy

Functional Family Therapy is a family-based intervention for youths with problem behavior. Goals include improving family communication and supportiveness, identifying solutions to family problems, and developing behavior change strategies. Therapists work with each family in a clinical setting or in-home treatment.

James F. Alexander, Ph.D.
1329 Behavioral Science
University of Utah
Salt Lake City, UT 84112
Phone: 801-581-6538
E-mail: jfafft@psych.utah.edu

Health Start Partnership and CARES Parenting Program

This intervention fosters secure mother-infant attachments by encouraging responsive parenting. For two years, cohorts of eight to 12 women with infants participate in home visits and weekly support and education groups. The program also provides medical care, lunch, and transportation.

Gloria Ferguson, Team Leader
491 West University Ave.
St. Paul, MN 55103-1936
Phone: 612-221-4368
E-mail: gloria.j.ferguson@healthpartners.com

Helping the Noncompliant Child

Helping the Noncompliant Child is designed for parents and their children ages 3 to 8 years with conduct disorders. Its long-term goals are prevention of serious conduct problems and juvenile delinquency in young children. Parenting skills are taught through demonstration, role-playing, and direct practice.

Robert J. McMahon, Ph.D.
University of Washington
Department of Psychology
Box 351525
Seattle, WA 98195-1525
Phone: 206-543-5136
E-mail: mcmahon@u.washington.edu

Home-Based Program: Coordinated Children's Services Initiative

The Coordinated Children's Services Initiative serves families of children with emotional and behavioral disabilities. Individualized care plans are developed with the family's needs in mind. The parent-training components focus on behavior modification.

Roberta Karant, Ph.D.
790 Park Ave.
Huntington, NY 11743
Phone: 516-854-9199

Home-Based Behavioral Systems Family Therapy

This intervention, based on the Functional Family Therapy model (discussed previously), reaches families with lower educational levels and higher levels of pathology than did the original model. The intervention is delivered in five phases, with increasing involvement of therapists. Its long-range goal is to reduce juvenile delinquency and teen pregnancy.

Donald A. Gordon, Ph.D.
Psychology Department
Ohio University
Athens, OH 45701
Phone: 740-593-1074
E-mail: gordon@ohiou.edu

HOMEBUILDERS

This intervention aims to strengthen the family and prevent foster care and out-of-home placement. It includes four to six weeks of intensive, in-home services to children and families. A practitioner provides counseling and services and is on call for crisis intervention.

Charlotte Booth, Executive Director
Behavioral Sciences Institute
181 South 333rd St., Suite 200
Federal Way, WA 98003-6307
Phone: 253-874-3630
E-mail: bsihomebuilders@wordnet.att.net

Home Instruction Program for Preschool Youngsters

HIPPY's goals include preventing academic underachievement by increasing literacy in the home and empowering parents to be educators and advocates for their children. The weekly intervention for economically disadvantaged parents and preschool-age children includes role-playing and other activities.

Barbara Gilkey
Arkansas Children's Hospital
800 Marshall Street, Slot 651
Little Rock, AR 72202
Phone: 501-320-3727
E-mail: bgilky@exchange.ach.uams.edu

The Incredible Years: Parent, Teacher, and Children Series

The Incredible Years offers support and problem-solving to parents of children ages 3 to 12. In the Parent Training Series, parents meet in groups with a trained leader to foster support, problem-solving, and self-management. The Teacher Training Series prepares teachers to present the separate Child Training Series.

Carolyn Webster-Stratton, Ph.D.
The Incredible Years
1411 8th Ave., West
Seattle, WA 98119
Phone: 206-285-7565
888-506-3562
E-mail: incredibleyears@seanet.com
Web site: www.incredibleyears.com

MELD

This parent education intervention uses peer support groups to help parents develop skills and confidence. MELD reaches out to parents of preschool children and has been adapted to address parents who are single, are of Hispanic and Southeast Asian descent, are deaf and hard-of-hearing, or have children with special needs.

Joyce Hoelting
123 North 3rd St., Suite 507
Minneapolis, MN 55401
Phone: 612-332-7563
E-mail: meldctrl@aol.com

Multisystemic Therapy Program

MST offers intensive family-based treatment to address determinants of serious antisocial behavior in adolescents and their families. General goals are to reduce rates of antisocial behavior and out-of-home placements and to empower families to resolve future difficulties. Individual treatment goals are developed in collaboration with the family.

Scott Henggeler, Ph.D., Director
Department of Psychiatry and Behavioral Sciences
Family Services Research Center
Medical University of South Carolina
Box 250861
67 President St., Suite CPP
Charleston, SC 29425
Phone: 843-876-1800
E-mail: henggesw@musc.edu

NICASA Parent Project

The NICASA Parent Project was designed to meet the needs of working parents of children from birth through adolescence. The intervention, presented at work sites during lunch time, focuses on child development, balancing work and family, and improving parenting skills.

Joyce Millman, Director of Parent Services
Northern Illinois Council on Alcoholism and
Substance Abuse (NICASA)
31979 N. Fish Lake Rd.
Round Lake, IL 60073
Phone: 847-546-6450
E-mail: joycemil@ais.net

Nurturing Parent Programs

There are 13 Nurturing Parenting Programs designed for specific cultures, family dynamics, and children's age groups. The programs build nurturing skills to reduce abusive parenting, juvenile delinquency, alcohol abuse, and teen pregnancy. Parents and children attend separate groups that meet concurrently. Each program has been researched and validated as an effective intervention for the treatment and prevention of child abuse and neglect.

Stephen Bavolek, Ph.D.
27 Dunnwoody Court
Arden, NC 28704-9588
Phone: 828-681-8120
E-mail: fdr@familydev.com
Web site: www.familydev.com

Parenting Adolescents Wisely

PAW is a self-administered interactive CD-ROM-based intervention designed for parents who are unfamiliar with computers. Parents view scenes of common family problems, choose a solution, and listen to a critique. The intervention helps families enhance relationships and decrease conflict while enhancing child adjustment.

Donald A. Gordon, Ph.D.
Psychology Department
Ohio University
Athens, OH 45701
Phone: 740-593-1074
E-mail: gordon@ohiou.edu
Web site: www.familyworksinc.com

Parents Anonymous

Parents Anonymous welcomes parents who are concerned about their parenting ability and seek support, information, and training. Parents set the agenda for each weekly two-hour meeting. Complementary children's interventions are offered concurrently. Basic parenting skills are discussed, and members offer 24-hour support to parents.

Teresa Rafael, M.S.W., Vice President of Programs
Parents Anonymous, Inc.
675 W. Foothill Blvd., Suite 220
Claremont, CA 91711-3475
Phone: 909-621-6184
E-mail: parentsanon@msn.com
Web site: www.parentsanonymous-natl.org

Preparing for the Drug Free Years

An intervention for parents of children in grades 4 through 8, PDFY seeks to reduce drug abuse and behavioral problems in adolescents by increasing parents' skills. The intervention focuses on family relations and conflict resolution and incorporates behavioral skills training and communication approaches to parent training.

Barbara McCarthy
130 Nickerson St., Suite 107
Seattle, WA 98109
Phone: 800-736-2630
E-mail: sales@drp.org

Project SEEK

Services to Enable and Empower Kids (SEEK) serves children ages 0 to 11 who have a parent in prison. SEEK's goal is to break the inter-generational cycle of criminality. The program includes home visits; advocacy and referral; support groups for children, adolescents, and caregivers; and communication with the inmate.

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806 Tuuri Place
Flint, MI 48503
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Raising a Thinking Child: I Can Problem Solve (ICPS) Program for Families

ICPS develops a set of interpersonal cognitive problem-solving skills for children up to age 7. The program's goal is to prevent more serious problems by addressing behavioral predictors early in life. Parents learn a problem-solving style of communication that guides young children to think for themselves.

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Strengthening Families Program

A family-skills training intervention, SFP was designed to reduce risk factors for substance use and other problem behaviors in high-risk children of substance abusers, but it has also been used widely with parents who are not substance abusers. The intervention addresses families with children 6 to 10 years old and provides classes for parents, children, and families.

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The Strengthening Families Program for Parents and Youth 10 to 14

The long-term goal of this intervention is to reduce substance use and behavior problems during adolescence. Intermediate goals include improved child management skills among parents and improved interpersonal and prosocial skills among youths. Parents and adolescents attend separate skill-building groups and also spend time together in supervised family activities.

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Strengthening Hawaii Families

This intervention, based on cultural values, seeks to prevent problems such as substance abuse and domestic violence. It aims at increasing resiliency in both the community and family. A 14-session curriculum provides tools and a process for families and children 5 to 12 years old to build on existing family strengths.

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Strengthening Multi-Ethnic Families and Communities

This intervention reaches out to ethnically and culturally diverse parents of children 3 to 18 years old with the goal of reducing violence against self, family, and community. Parent-training classes are held at various community locations. The curriculum is delivered in 12 sessions of three hours each; materials are available in several languages.

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Structural Family Therapy

This intervention for Hispanic and African American families addresses youths who abuse drugs and exhibit behavior problems. Therapists implement tailored activities to change negative patterns of family interactions and create opportunity for more functional interactions.

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Treatment Foster Care

This parent-training intervention works with foster parents to provide placements for adolescents ages 12 to 18 who are referred because of chronic delinquency. Treatment foster parents implement a daily behavior management plan over the course of six months. The adolescents participate in weekly therapy, and their biological parents also receive treatment.

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Strategies to Prevent Youth Violence

- Home-Visiting Strategy

Jim Gathany—CDC, 2000

Overview of the Home-Visiting Strategy

Violent and criminal behavior, poor mental health, drug use, and poor school performance have been linked to several childhood risk factors, including child abuse and neglect, poverty, a poor relationship with the parent(s), poor physical and mental health, parental drug or alcohol abuse, and child abuse and neglect (Wolfner and Gelles 1993; Oates et al. 1995; Krysik et al. 1997; Norton 1998). By eliminating these risk factors, we can help reduce the aggressive and violent behaviors we see in our schools and communities. Home visiting is one effective strategy to address these factors.

Home-visiting interventions bring community resources to at-risk families in their homes.

Home-visiting interventions bring community resources to at-risk families in their homes. During home visits, intervention staff provide information, healthcare, psychological support, and other services that participants need to function more effectively as parents. These programs have helped improve maternal health and pregnancy outcomes, increase employment and education among young parents, reduce reliance on welfare, improve children's mental and physical health, reduce childhood injuries, and reduce criminal behavior by young people. This strategy is ideally implemented with families who are expecting or have recently had their first child.

Best Practices of Home-Visiting Interventions

Although additional research is needed to evaluate the effectiveness of home-visiting interventions, several studies have revealed promising findings as well as techniques and principles for planning and implementing these efforts. This section presents the practices identified in those studies, along with recommendations from experts in the field of youth violence prevention.

Identify the Populations You Want to Reach

Many European countries provide home visits to all families, regardless of risk status. Some advocates have argued that this service should be made available to all families in the United States, as well. But home-visiting interventions are resource-intensive, and few communities have the financial and human resources needed to carry out an effective program on such a large scale. Therefore, targeting select groups for home-visiting services is typically most appropriate. A needs assessment conducted with input from the community will help identify families who could benefit most from a home-visiting intervention. Community leaders should play a key role in this decision, as they are often in a position to direct the allocation of resources.

Expectant parents and first-time parents

Research suggests that home visiting has the greatest impact when it begins early in the parenting process. Therefore, home-visiting interventions often begin when participants are pregnant and continue through the first few years of the children's lives. Targeting first-time parents seems to be ideal, the rationale being that positive changes will carry over to future pregnancies and children. In addition, research indicates that mothers involved in a home-visiting intervention will likely have fewer unintended pregnancies (Olds and Kitzman 1990).

Olds and colleagues (1998) examined the long-term effects of prenatal and early-childhood home visits on children's antisocial behavior. They found that adolescents whose mothers had been visited by nurses expressed less antisocial behavior and had lower substance-use rates than the adolescents in a comparison group. Adolescents from the study group also reported significantly fewer instances of running away, fewer arrests, fewer convictions and violations of probation, fewer lifetime sex partners, fewer cigarettes smoked per day, and fewer days having consumed alcohol in the six months preceding the study.

Similar results were achieved by Aronen and Kurkela (1996). They studied the long-term effects of a home-based family-counseling intervention that took place during the first five years of the children's lives. Eighty families experienced 10 home visits per year; another 80 families served as a comparison group. Both groups included low-risk and high-risk families. At age 15, each child's mental-health status was assessed. Adolescents in the intervention families had significantly fewer mental health symptoms on child-behavior checklists filled out by their parents and on the youths' self-reports. The counseling predicted better mental health at year 15 for both high- and low-risk families.

Home visits seem to benefit high-risk families most.

High-risk families

Although positive results have been achieved among both high- and low-risk families, home visits seem to benefit high-risk families most. One study found that home-visiting interventions produce the greatest benefit when they are focused on single and adolescent parents living in communities with high poverty rates (Olds and Kitzman 1990; Olds et al. 1997). Interventions aimed at poor, unmarried mothers have been shown to improve the maternal life course, reduce the number of months that mothers relied on public assistance and food stamps, reduce behavioral problems associated with alcohol and other drug use, and reduce the number of arrests (Olds et al. 1997).

Daro (1993) found that families exhibiting child abuse and neglect responded best to interventions incorporating home visits. One of the most important benefits reported for these families was the concrete assistance that visiting practitioners offered in resolving childcare problems such as discipline and toilet training.

Remember that, although home visits can bring about substantial changes in the long run, they can rarely bring about immediate changes in the environmental, financial, and psychological issues that high-risk families face. Long-term dedication is needed to affect social adversities such as unemployment, poverty, drug abuse, and malnutrition.

Other groups

Young people who drop out of high school or show poor school engagement are at increased risk of becoming teen parents (Manlove 1998). As discussed previously, young, unwed parents are often at increased risk of developing parenting styles that are associated with the development of youth violence. And given that dropping out of school, poor academic performance, and a

general lack of interest in school are, by themselves, risk factors for developing violent behavior, this group is an appropriate target for home visits.

Parents with limited social support are also ideal participants in home-visiting interventions. These parents need help dealing with the stress of parenting and with other life stressors such as financial and marital difficulties or unemployment.

Generate Support in the Community

You will need a great deal of support from your community—in the form of both financial and human resources—to carry out a home-visiting intervention. To convince community members and leaders that your intervention is worth their time and money, show them how the intervention will meet the community's perceived needs and goals and explain the long-term benefits of early prevention efforts. Here are a few arguments for conducting a home-visiting intervention:

- Helping expectant mothers to stop using drugs or alcohol and to eat a better diet will improve the health and development of their babies.
- Improving parent-child interactions from the earliest possible time will help prevent abusive disciplinary tactics.
- Addressing parents' physical and emotional needs will increase their patience and tolerance, making them better able to nurture their children.

In addition to preventing the risk factors for violence, home-visiting interventions may save communities money down the road. Data on the cost-effectiveness of home visits are limited, and additional studies must be conducted (Barnett 1993), but a few cost analyses have revealed savings in government spending for food stamps and the Temporary Assistance for Needy Families Program (formerly the Aid to Families with Dependent Children Program).

Set Clear Goals and Objectives

Setting goals and objectives for home visits must be done on two levels. First, practitioners should identify the desired outcome of the intervention. For example, an overall goal might be to reduce the number of elementary school students who exhibit early warning signs of developing violent behavior, such as withdrawing from classmates and performing poorly in school. Objectives, then, might be to improve the parent-child interactions in families of preschoolers and to help parents develop educational activities to better prepare their children for school.

On the second level, home visitors must help each family set its own goals and objectives. This will ensure a good balance between the intervention's goals and the family's needs. It will also help parents feel ownership of the intervention because they will be working toward something they feel is important to their family.

Design the Best Intervention for Your Participants

The interventions that succeed in helping at-risk families are intensive, comprehensive, and flexible.

The activities and materials you develop for your home visits will depend on the characteristics and needs of the participants, your goals and objectives, and the expertise of the home visitors. Overall, the interventions that succeed in helping at-risk families are intensive, comprehensive, and flexible (Wallach 1994). The following principles will apply to all home-visiting interventions:

- Each component of a home-visiting intervention should build on or relate to the others; home-visit activities should be synergistic.
- Home visits should focus on the parent-child interaction and on the relationship between the parents.
- Home visitors should address the child's physical and mental health and development; activities should be appropriate for the child's age.
- Appropriate discipline techniques should be taught and appropriate behavior modeled by home visitors.

Home-visiting interventions should also help parents build support networks. By linking them to community organizations, churches, medical-care providers, and other services, home visitors can help parents obtain assistance with finances, emotional problems, and other needs.

For expectant mothers and parents with young babies

In a randomized trial in Elmira, New York (a semi-rural community), Olds and Kitzman (1993) demonstrated the effectiveness of nurse home visits for first-time pregnant teens who were poor or unmarried. The home visits were designed to improve the mothers' health, help them develop effective parenting skills, and improve their financial situation by easing the transition into the work force after their children were born. The goal was to reduce problems resulting from poor prenatal health, dysfunctional caregiving, and financial difficulties caused by closely spaced pregnancies, lack of education, and inconsistent employment.

The study produced encouraging results. Compared to controls, nurse-visited women experienced greater social support—both from family and friends and from government and community services. They also smoked fewer cigarettes, had better diets, and suffered fewer kidney infections during pregnancy. Through age 2, children born to nurse-visited women were 80 percent less likely to be identified as victims of child abuse or neglect and were seen in hospital emergency departments 56 percent fewer times. Four years after delivery of the first child, the women in the intervention group had 42 percent fewer additional pregnancies and participated in the workforce at a rate 84 percent higher than that of the control group. The cost to the government for this intervention was recovered before the children's fourth birthdays (Olds et al. 1993).

A follow-up of the original Elmira study revealed that positive results endure (Olds et al. 1997; Olds et al. 1998). Fifteen years after the initial intervention, data showed a reduction from 90 months to 60 months of recourse to the Aid to Families with Dependent Children Program among low-income, unmarried mothers. The home visitation program was also replicated in Memphis, Tennessee, among a predominantly black population. Results, although smaller in magnitude, were similar to those obtained in the semi-rural, mostly white community. (Olds et al. 1999; Kitzman et al. 1999).

For families with evidence of child abuse or maltreatment

Previous research suggests that the incidence of child abuse increases the odds of future delinquency and adult criminality by 40 percent (Widom 1992). A high percentage of juvenile sex offenders may have been victims of childhood violence themselves (Feindler and Becker 1994). Studies and interviews with experts have found home-visiting interventions to be effective in reducing the risk for and incidence of child abuse and maltreatment (Brust, Heins, and Rheinberger 1998; Carnegie Corporation 1994).

Wasik and Roberts (1994) conducted a survey of 1,904 home-visiting interventions, 224 of which stated their primary focus was to provide services for abused and neglected children and their families. More than three-quarters of respondents rated three key elements of home visits as being of primary importance—improved parent-coping skills, enhanced parenting skills, and emotional support. Stress management, enhanced child development, and child and family advocacy were also rated as high priorities by more than half of respondents.

A successful home-visiting program aimed at preventing child abuse and neglect is Hawaii's Healthy Start Program, established in 1985 as a demonstration project. It now reaches more than half of Hawaii's at-risk population. This program uses home visits to improve families' coping skills and functioning, promote positive parenting skills, foster healthy parent-child interactions, and promote optimal child development. Results of the initial three-year project were conclusive: not a single case of abuse occurred among the project's 241 high-risk families (Breakey and Pratt 1991, 1993).

The Healthy Start Program offers a systematic approach to preventing child abuse among at-risk infants and toddlers. This approach forms the foundation for programs developed through Healthy Families America (HFA), a partnership of Prevent Child Abuse America (formerly the National Committee to Prevent Child Abuse) and the Ronald McDonald House Charities. While each state has autonomy in designing and implementing its HFA programs, key components include the following (Daro and Harding 1999):

- systematic hospital-based screening to identify high-risk families
- home visits to provide family support services
- individualized plans for continuing service based on family need and risk level
- linkage to medical services (e.g., immunization and well-baby check-ups)
- coordination with and referrals to other health, counseling, and social services

Results indicate that this approach reduces child abuse, somewhat improves the home environment, improves children's healthcare and development, and reduces reliance on public assistance (Krysik et al. 1997; Norton 1998). A list of state HFA contacts is included in the *Additional Resources* section for this strategy.

Select Staff Appropriate for Your Intervention

Home visits may be conducted by a variety of individuals—public-health or registered nurses, social workers, paraprofessionals, volunteers, and advocates and liaisons. For most home-visiting interventions, however, a health professional or paraprofessional specifically trained to make home visits will be best able to achieve the results desired.

Before you select your staff, develop a framework for your intervention that specifies the job roles and responsibilities of all staff members. Base hiring, training, and supervision on that framework. Be sure to hire staff whose experience and educational background fit the requirements of your intervention. For example, if your objectives include improving the health of pregnant women and their babies, nurses will be most appropriate; on the other hand, if your aim is to improve the learning skills of preschoolers in participating families, you may need staff with a teaching background.

Nurses

Public health nurses may be the best choice for your intervention's staff.

Public health nurses appear to be in a position to detect community problems and trends before other health care providers (Bekemeier 1995). They may be the best choice for your intervention's staff, especially if your intended participants are at-risk pregnant women.

The expertise nurses possess appears to be well accepted and even desired by most expectant parents because their focus is on health—first, that of the pregnant woman and later, that of the baby. In addition, families may feel more at ease in asking for help from a nurse than from social-service professionals or counselors because there is less of a potential stigma associated with nursing assistance. In fact, a pregnant woman's asking for nurse-related assistance may be viewed as a sign of her positive intentions toward her health and that of her baby.

Nurses are also ideal home visitors because:

- they can deliver content that contains a lot of medical information;
- they are trained to teach, use good questioning techniques, detect subtle cues, set priorities, and manage cases;
- they have an accepted role in the lives of pregnant women that can facilitate early acceptance and trust.

Paraprofessionals

For some interventions, paraprofessionals—counselors, social workers, and specially trained community volunteers—will be effective home visitors. An intervention implemented as a randomized controlled trial in Denver, Colorado, compared the effectiveness of paraprofessionals and nurses in improving pregnancy outcomes, infant care, and parental life course. Overall, nurses produced a larger and broader range of beneficial effects: improved prenatal health behaviors, improved viability

of the newborn, more effective infant care, increases in the children's language development, and decreased rates of subsequent pregnancy. However, paraprofessionals effected significant changes, as well. The environment of the homes visited by paraprofessional became more conducive to children's development (at 21 months); early postpartum participation in the workforce was achieved by women of low psychological resources; and women had lower rates of subsequent pregnancy.

More studies are needed to determine under what circumstances paraprofessionals trained in home visiting can be most effective. Researching intended participants can help identify the kinds of paraprofessionals who are most likely to be trusted and accepted by families. With both nurses and paraprofessionals, the beneficial effects of home visits are attributable to the particular program model and to the protocols that guide their visits (Olds 1998).

Staff characteristics

Whether you employ nurses, paraprofessionals, or others, all staff must be available to conduct home visits when it is most convenient for participants. Since welfare reform, more mothers are working and may only be available on weekends or evenings. Staff must also be committed to the effort and must get to visits on time, attend every visit, and complete the intervention. To be successful, home-visiting interventions rely on the development of a trusting relationship between the participants and the visitors. Tardiness and inconsistent attendance erode that trust.

The following characteristics are also highly desirable for home visitors:

- motivation, self-confidence, and a good sense of humor
- empathy and an open mind
- an understanding of the principles of parenting and child development
- sensitivity to cultural customs and political issues
- good communication skills
- critical-thinking and problem-solving abilities
- ability to relate to people of diverse backgrounds

Special considerations for home visitors

Because intervention staff will be going into participants' homes and discussing potentially sensitive issues, practitioners must consider several factors when selecting staff and pairing them with participating families.

Confidentiality

Staff members must not be allowed to conduct visits in the homes of family members or friends. Participants may be reluctant to share with people they know details about problem behavior (e.g., child abuse, drug use) or concerns about their parenting abilities. All home visitors should sign an agreement of confidentiality to protect the privacy of the participants. However, practitioners should identify emergency circumstances in which home visitors may violate that agreement in order to help the family (e.g., when the health or safety of participants is endangered).

Male home visitors

Carefully assess the context and sensitivities of the intended participants before selecting men to be home visitors. Some fathers—in particular, single fathers—may be willing to participate in an intervention led by a man. However, other fathers may feel competitive or even hostile toward a male visitor. Many visits are conducted in homes where a father is not present. Single mothers may feel unsafe or uncomfortable with a male visitor. When male visitors are undesirable to your participants, try having them accompany the primary home visitor occasionally as an auxiliary with special expertise.

Cultural issues

Matching the cultural background of a home visitor with that of the family may or may not be important. The preferences of your intended participants should dictate this decision. Regardless of the cultural background of the home visitor, he or she must portray a neutral orientation toward race, ethnicity, religion, and other cultural factors.

Train Staff Members

Training that prepares staff members for home-visiting work is essential, regardless of their prior education and experience. Practitioners should determine the core competencies staff will need to meet the intervention's goals and objectives and ask staff to provide input about their training needs. At a minimum, the training curriculum should cover the following topics:

- protocol for home visits (what it's appropriate for visitors to do)
- pregnancy health, transition to motherhood, and parent-child bonding and attachment
- signs of and risk factors for child abuse and neglect
- developing a trusting relationship with participants
- setting goals and resolving disagreements
- steps for creating a safe home environment for children
- signs of and referral information for mental health problems, substance abuse, and domestic violence
- personal safety for the home visitor

In most cases, professional staff (those with a 4-year college degree) should receive 80 hours of training; paraprofessionals should receive 200 hours. Provide opportunities for role-playing so staff can practice new skills and offer feedback. And develop a training manual to complement in-class activities and serve as a reference during implementation.

You will probably need to engage in intensive outreach to bring families into your program.

Recruit Participants

Participation in home-based interventions must be voluntary. In an ideal world, families would jump at the chance to participate in your intervention. But in reality, you will probably need to engage in intensive outreach to bring families into your program. Families may be reluctant to participate because they:

- feel insulted by the implication that they need help;
- view intervention staff as "the establishment";
- fear discovery of illicit activities;
- view visits as an invasion of privacy.

Additionally, new mothers may be tired or depressed and may not have the energy to engage. They may also feel they do not have time for visits.

Implement Your Intervention

Implementing home-visiting interventions poses complex challenges. Home visitors must address a variety of often-changing issues related to the families' circumstances. And in many cases, a long time period is required to achieve relatively small changes.

Match the intensity, frequency, and duration of your intervention with families' needs

How long your intervention continues, how often visits occur, and how long each visit lasts will depend on the families' needs and the goals set for your effort (Brust, Heins, and Rheinberger 1998; Powell 1993). On average, home-visiting interventions last about one year; more intensive programs may run as long as three to five years. Home visits most commonly occur on a weekly basis. Monthly visits are the minimum for families with infants and very young children; for families of older children, quarterly visits may be appropriate if the intervention incorporates other forms of community support. Most visits last between 30 minutes and one hour, but they may run longer (Wasik and Roberts 1994).

The frequency of visits may decrease as families mature in the intervention, are successfully linked to needed services, and master the skills and information set forth in the intervention objectives. If parent-group meetings are part of the intervention, alternate the weeks of home visits with those of group meetings.

Each visit should have a clear structure and set activities. To keep activities on track, focus on long-term goals. At the end of each visit, note progress and discuss how upcoming activities reflect mutual expectations. Creating a "contract" with participants might be useful in determining what should be achieved during each visit. While it's important to form a comfortable relationship with participants, visits should not become social gatherings. Also, the content of visits should not be driven by crises.

While it's important to form a comfortable relationship with participants, visits should not become social gatherings.

Encourage participants to stay involved

Participants in home-visiting interventions often drop out. They may become discouraged when changes occur very slowly, or they may come to believe that they no longer need the services home visits provide (Olds and Kitzman 1993). Home visitors need to keep participants committed to the intervention. The following tips can help:

- Be flexible. Balance the need to follow delivery protocol with the family's objectives and circumstances.
- Resolve differences immediately. Listen carefully to participants' concerns and respect their points of view.
- Provide empowering feedback. Seek opportunities to reinforce parents' positive behavior, especially in bonding with a new baby or in responding to the baby's cues.

- Use video feedback. Film interactions between parents and child. Highlight the child's developmental milestones.
- Involve children in activities. Help parents identify family activities that are appropriate for the children's ages and interests.
- Involve other family members, but not so many or so often that the parent-visitor dialogue is disrupted. Let participants define who "family" is.
- Schedule fun activities, such as singing, storytelling, and going to a park or community event.

Support intervention staff

To help prevent staff burnout, limit the caseloads of home-visiting staff to no more than 15 families; in some communities, caseloads will be significantly smaller (HFA 1996). Strongly caution staff against getting involved in family problems they are unqualified to handle. For example, home visitors should not play therapist if participants appear to be suffering from depression or other mental health problems. Families should be referred to community resources for crisis issues.

During implementation, provide staff with ongoing opportunities for training and group discussions. Keep lines of communication open so staff can approach supervisors with concerns or questions at any time. Supervisors should watch staff closely for signs of fatigue, discouragement, and difficulty with implementing activities.

Monitor Progress and the Quality of Your Intervention

As with any prevention effort, a home-visiting intervention must be monitored to make sure it is on schedule and on track. Collecting data throughout implementation can help you verify that activities are being carried out as planned and help you identify early problems in delivery that may jeopardize the intervention's success. The following suggestions should help you effectively monitor your effort:

- Supervise intervention staff closely to make sure they are following the protocol for home visits.
- Have staff record procedures as they are completed.
- Encourage participants to communicate concerns (e.g., if they feel their needs are not being met).
- Ask participants to keep a log of activities (every third visit is usually sufficient).

- Record qualitative observations as well as quantitative, but keep recording to a minimum so it does not become disruptive.
- Find out—through surveys, focus groups, or visits by supervisors—why drop-outs left the intervention. The data you gather may help you improve the intervention.

Monitoring data should be reviewed frequently. Remember that no intervention goes exactly as planned. If procedures or activities are deemed ineffective or problematic, they should be altered or discontinued (Slaughter-Defoe 1993).

Evaluate Changes

To determine whether your intervention has met its goals, note changes in participants' behaviors and in family interactions as the intervention progresses. Compare them to baseline data established when implementation began to determine if the intervention resulted in positive outcomes.

Have parents note improvements in their behavior and that of their children and in parent-child interactions. Parents can also evaluate their confidence in parenting and handling conflicts that occur in the home. Home visitors, especially nurses, can assess the health and development of the children, as well as evaluate the behavioral changes they observe. If the children attend school or a childcare program, teachers and caregivers can also provide data about the children's behavior.

Maintain Results After Implementation

To sustain the positive effects of the intervention, develop a strategic plan to help participants with the transition that occurs when the intervention ends. For example, you might schedule quarterly "boosters" or direct parents to community organizations that can provide support. Consider offering incentives such as diplomas and graduation ceremonies to foster transition.

Anticipate the need for follow-up interventions. Keep track of families after the initial intervention ends so it's easier to locate them. Sending Christmas cards and Mother's and Father's Day cards, for example, can help keep addresses current. By sharing success stories with funders and policy-makers, you can gain support for follow-up activities.

Link Home Visits with Other Strategies

Home visits are an effective component of programs seeking to prevent violence by young people, but they may not be sufficient on their own (Weiss 1993). Although more research is needed to test the hypothesis, combining early home-based interventions with school programs and other community efforts may be an effective strategy in preventing violence and other negative health outcomes.

Summary

Home-visiting interventions improve parenting skills, provide social support to families, recognize and manage behavior problems, and promote child health and development. These types of interventions are likely to have a far greater impact on delinquency and violence than secondary and tertiary prevention programs such as those of the criminal justice system (Rivara and Farrington 1995).

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Slaughter-Defoe DT. "Home Visiting with Families in Poverty: Introducing the Concept of Culture." *Future of Children* 1993;3(3):172-183.

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Wasik BH, Roberts RH. "Survey of Home Visiting Programs for Abused and Neglected Children and Their Families." *Child Abuse and Neglect* 1994;18(3):7271-283.

Weiss HB. "Home Visits: Necessary But Not Sufficient." *Future of Children* 1993;3(3):113-128.

Widom CS. “The Cycle of Violence.” National Institute of Justice: Research in Brief, October 1992. Cited in Feindler EL, Becker JV. “Interventions in Family Violence Involving Children and Adolescents.” In: Eron LD, Gentry JH, Schlegel P, editors. *Reason To Hope: A Psychosocial Perspective on Violence and Youth.* Washington, DC: American Psychological Association, 1994: 405-430.

Wolfner GD, Gelles RJ. “A Profile of Violence Toward Children: A National Study.” *Child Abuse and Neglect* 1993;17(2):197-212.

Additional Resources on Home-Visiting Interventions

Publications

The following publications contain helpful information about home-visiting interventions.

Barnard KE. "Developing, Implementing, and Documenting Interventions with Parents and Young Children." *Zero to Three* 1998; 4(February/March):23-29.

Barnard discusses the three issues that intervention planners, administrators, researchers, and policy makers must address: the implementation gap (the capacity to implement the interventions as conceptualized), the relationships between participants and the intervention staff/therapists, and the need for more intervention focus with parents and young children.

Zero to Three: National Center for
Infants, Toddlers and Families
734 15th St., NW
Washington, DC 20005
Phone: 202-638-1144
Web site: www.zerotothree.org

Cohen LR, Shaeffer LG, Gordon AN, Baird TL. *Child Development, Health, and Safety: Educational Materials for Home Visitors and Parents.* Gaithersburg, MD: Aspen Publishers, 1996.

A compilation of educational materials for use by home visitors to help prevent unintentional injuries and child abuse and neglect. The focus on preventing abuse and neglect is implicit rather than explicit so parents will not feel as though they are being targeted as potential abusers.

***The Future of Children* 1993; 3(3).**
***The Future of Children* 1999; 9(1).**
Published by The David and Lucile Packard Foundation, both issues are dedicated to home-visiting interventions. Articles describe the status of home-visiting interventions, recommend how to expand or improve home-visiting interventions, describe the diversity among families served by home-visiting interventions, and discuss recommendations by the U.S. Advisory Board on Child Abuse and Neglect to implement a national program of universal home visiting as a strategy to prevent child abuse and neglect.

David and Lucile Packard Foundation
300 Second St., Suite 200
Los Altos, CA 94022
Phone: 650-948-7658
Web site: www.packfound.org

Hanks C, Kitzman H, Milligan R. "Implementing the COACH Relationship Model: Health Promotion for Mothers and Children." ***Advances in Nursing Science*** **1995; 19(2): 57-66.**
The COACH Relationship Model was part of a clinical trial to study the effect of nurse home visitation in improving the health-related behaviors of low-income mothers. After being taught the program's theoretical underpinnings (caring, ecological, role supplementation, and self-efficacy theories), nurses developed program materials to translate the concepts into nursing interventions.

Health Care Coalition on Violence. ***A Review of the Research on Home Visiting: A Strategy for Preventing Child Maltreatment.*** **Anoka, Minnesota: Health Care Coalition on Violence, 1998.**
A review of 42 home-visiting research articles that describe child maltreatment in the United States and Minnesota, summarize the current research on home visiting, and recommend a future research agenda for home-visiting services. The review concludes that home visiting is an effective strategy for reducing the incidence of and risk for child maltreatment, but it leaves unresolved the components necessary for an effective program and the costs and benefits compared with other interventions.

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***Healthy Families America (HFA) Community Planning and Site Development Guide,* January 1997.**
Includes general HFA information; how to determine community needs; starting and implementing an HFA program; training; and research, evaluation, and quality assurance. Appendices include policies, sample worksheets, and 10 site summaries.

Prevent Child Abuse America
(formerly the National Committee to Prevent Child Abuse)
200 South Michigan Ave., 17th Floor
Chicago, IL 60604-2404
Phone: 312-663-3520
Fax: 312-939-8962

Healthy Families Indiana. Strategic Plan (1996) and Evaluation of Training (10/93-9/95).
Healthy Families Indiana is a home-visiting intervention that provides long-term benefits to Indiana's families and children through services that promote family functioning and parent-child interaction, improve family and child health, and enhance child development.

Family and Social Services Administration/DFC
402 West Washington St., Room W364
Indianapolis, IN 46204
Phone: 317-232-4770
Fax: 317-232-4436

***Journal of Community Psychology* 1997; 25(1).**
***Journal of Community Psychology* 1998; 26(1).**
These issues discuss home visiting exclusively.

MacMillan HL, MacMillan JH, Offord DR, Griffith L, MacMillan A. "Primary Prevention of Child Physical Abuse and Neglect: A Critical Review. Part I." *Journal of Child Psychology* 1994; 35(5):835-856.
This article reviews the effectiveness of prospective controlled trials, published between January 1979 and May 1993, aimed at the primary prevention of child physical abuse and neglect. Interventions were classified into six categories within the broad group of perinatal and early childhood programs. Many of these programs did not show a reduction in physical abuse or neglect; however, there is evidence that extended home visitation can prevent physical abuse and neglect among disadvantaged families.

Oregon State University Healthy Start Evaluation Project. *Oregon's Healthy Start Effort, 1996-97 Status Report,* December 1997.
Includes history, goals, Healthy Start model, reaching first-birth families, family assessment, participation, family characteristics, engagement and retention, and family satisfaction.

Family Study Center
Oregon State University
203 Bates Hall
Corvallis, OR 97331-5151
Phone: 541-737-2035

Powers M. "An Ounce of Prevention: Prenatal Care and Postnatal Intervention for At-Risk Mothers." *Human Ecology Forum* 1995; 23(1):19-22.
This article describes a 5-year longitudinal study to determine the sustainability of promising effects revealed in earlier studies, including better pregnancy outcomes, improved child care practices, fewer cases of child abuse, less reliance on social services, and a better life for mothers.

***Zero to Three, Home Visiting with Families with Infants and Toddlers* 1997; 17(4).**
The entire issue is about home visiting. Various authors discuss the benefits and dilemmas of home visiting as a strategy to support families with infants and toddlers. Topics include universal access, intensive outreach to at-risk families, and community development as the ultimate goals. The overarching theme is that home visiting is a powerful tool but it is only the beginning of the work at hand.

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Home-Visiting Programs

You may wish to contact the programs listed below, which have home-visiting components.

First Steps/Fremont County Family Center

First Steps offers comprehensive child-development and parenting services for families with children from birth to 5 years. The intervention, which operates as part of the Fremont County Family Center, also provides monthly home visits. Play groups are held 4 times a week for children, siblings, and parents.

Katherine Bair, Homevisiting Coordinator
1401 Oak Creek Grade Rd.
Canon City, CO 81212
Phone: 719-269-1523
E-mail: fcfc@ris.net

Health Start Partnership and CARES Parenting Program
This intervention fosters secure mother-infant attachments by encouraging responsive parenting. For 2 years, cohorts of 8 to 12 women with infants participate in home visits and weekly support and education groups. The program also provides medical care, lunch, and transportation.

Gloria Ferguson, Team Leader
491 West University Ave.
St. Paul, MN 55103-1936
Phone: 612-221-4368
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Healthy Families Indiana
This voluntary home-visitation intervention is designed to promote healthy families and children. The intervention serves at-risk families with children from birth to 5 years. The family support worker visits weekly and helps increase parenting skills, healthy pregnancy practices, and referral to community resources.

Phyllis Kikendall
Indiana Family and Social Services Administration
402 West Washington St., W384
Indianapolis, IN 46204
Phone: 317-232-4770

Prenatal and Early Childhood Nurse Home Visitation Program
In this intervention, visits by nurse home visitors improve the health and social functioning of low-income first-time mothers and their babies. The home visits begin in pregnancy and continue until the child is 2 years old. Visit protocols focus on personal health, environmental health, maternal role, maternal life course, and family and friend support.

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